



Pamela Geraghty, LCSW, CHt
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INSURANCE INFORMATION

Name of Client _____

Client's Date of Birth _____

Name of Insurance Company _____

Name of Insured _____

Insured's Date of Birth _____

Insured's SSN _____ Client's SSN _____

Group Number _____

Member Number _____

Insurance Co. Phone Number _____

Insurance Co. Billing Address _____

Insured Employed By _____

Employer's Phone Number _____

Employer's Address _____

By signing here, you authorize Pamela Geraghty, LCSW, CHt, to bill and release information to your insurance company.

Print Name _____

Signature _____ Date _____